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PROLOGUE

the week of February 11, 1980, a public notice appeared in Ohio newspapers serving more than 50,000 announcing the general ... of the department's proposed revision in the rate-setting methodology for nursing home services to become effective July 1, 1980. ... date, time, and place of the public hearing, and the place where copies of the proposed rules could be obtained was announced. On or ...ut March 1980, a more detailed notice covering the same subject areas was sent certified mail to all nursing home providers. On or about April 8, 1980, a copy of the proposed rules was mailed to all providers and all other individuals who had expressed an interest in receiving a copy. In addition, the department conducted seven seminars across the state (which were attended by 2,500 individuals) describing the general provisions of the department's proposed rate-setting methodology, the specific provision of the patient assessment system, and the date and time of the public hearing.

On April 25, 1980, a public hearing was held regarding the department's proposed rules. The following pages summarize the general nature of the comments offered at the public hearing and in the written testimony received by the department up through the close of the public comment period (May 1, 1980). This Prologue also contains a brief explanation of the reasons outlining the department's acceptance or rejection of suggestions for modification.

The department received testimony from the organization for philanthropic nursing homes (Association of Ohio Philanthropic Homes for the Aging), a organization for the mentally retarded (the Ohio Private Residental Association), two organizations representing proprietary nursing homes (Ohio Health Care Association and the Academy of Nursing Homes), nursing home owners, individuals representing their nursing home clients (accounting firms, legal firms, etc.), nursing home administrators, social workers, nurses, and client advocates.

General Concerns

Some of the testimony was directed at general concept of rules adoption, and philosophical objection to establishing various tests of reasonableness. Concerns were expressed over the relatively short time for review from the date most providers received the proposed rules (16 or 17 days for most providers before the public hearing and 21 or 22 days before the end of the public hearing process). On the other hand, the department also received many compliments for the efforts made in publishing the public hearing, and in providing the rationale for the rules and the patient assessment system both in written form and verbally. As a matter of information, there are no requirements under federal or state law specifying a minimum number of days the proposed rules must be available before the hearing, or even that there be a public hearing.

Concerns were also expressed regarding the style, format, and organization of the rules. Part of the problem is the requirements of law regarding rule format. Requests were made that all explanatory statements be removed. Others wanted more detail and explanation in the rules. The publication of the rules in final format (without old language) may make them more readable, but the department does recognize the need for the department's policy to be stated in more readable and understandable handbook format.

... individuals raised questions regarding the authority of the department to propose (and eventually adopt) rules on matters not s... ...cally covered by provisions of state law. The department's position is that enabling legislation (Amended Substitute House Bill 176) provides the framework within which the department can adopt rules pursuant to ORC 111.15.

...iously, the department cannot adopt a rule in conflict with provisions of state law. Obviously also, it needs to adopt rules on areas not addressed by state law—e.g., rent and lease payments.

Objections were raised on five general areas:

- Existing rules regarding provisions of provider agreements applicable to all providers, identification of fraud, reasons for suspension/termination of providers, appeal process, policy monitoring, etc.

  Numerous philosophical and legal objections were raised regarding the department's existing rules. Except for a few minor corrections, the department had not proposed to revise these regulations in the implementation of Amended Substitute House Bill 176. Much more careful analysis of the nature of these objections needs to be made before revision. The point s that these are existing regulations unaffected by the passage of Amended Substitute House Bill 176; that the adverse actions are appealable under the provisions of Chapter 119 of the ORC; that payments continue through the appeal process until the final decision is rendered; and that the problems foreseen by the testifiers are anticipated problems which have not existed in the past. The issues raised are generally beyond the scope of the rules proposed for public hearing to resolve.

- The rules regarding the patient assessment system, the criteria used, the process followed, and the components of the formula.

  At the time Amended Substitute House Bill 176 was being deliberated, patient assessment (with its linkage to Medicaid reimbursement) was a new concept for which there was very little precedent. For this reason, the General Assembly specifically enacted ORC 5111.23 which states: "Reasonable and allowable nursing and habilitation costs shall be established and adjusted by rule of the Department of Public Welfare" and ORC 5111.29 which states: "...the department shall, by rule, establish such a (sic: patient assessment) system..." The patient assessment system, essentially as presented in February seminars and in rules, was submitted to and approved by the Controlling Board as required by ORC 5111.29.

  The rules regarding what constitutes reasonable costs allowable under the Medicaid program. Objections were raised regarding the authority of the department to propose that costs above certain ceilings were unreasonable (e.g., dietary personnel, medical supplies, etc.) or that other costs were nonallowable (home office costs/management fees, owner compensation paid in excess of prevailing wages, etc.).

  Amended Substitute House Bill 176 stated that nursing and habilitation costs, dietary costs, utility costs, and property taxes "...shall be ...ed on actual, ***allowable*** costs [ORC 5111.23(D)]; that administrative and general services costs shall be "... the median of the pre...ng cost reporting period's audited actual, ***allowable***..." costs [ORC 5111.24(A)]; and that property costs shall be based on the actual, ***...owable*** costs of the previous year [ORC 5111.25(A)]. (Emphasis added)

  The general authority to establish reasonableness ceilings is found at ORC 5111.20(A) which states: "Allowable costs" are those costs determined by the department to be reasonable..." In establishing the various tests of reasonableness, the department relied upon the guidance provided by the U.S. General Accounting Office's various reports on the nursing home program and the Ohio Nursing Home Commission's report entitled "A Program in Crisis: Blueprint for Action." The latter report was particularly relied upon because it provided the basis and rationale for reimbursement methodology contained in Amended Substitute House Bill 176. In addition, as a result of the report's findings, the Nursing Home Commission drafted and sponsored Amended Substitute House Bill 176.

The viewpoint expressed by many providers and attorneys representing these providers was that the state law only permitted the dep ment to establish various "tests of reasonableness" which individual providers could exceed upon documentation that the excess w not unreasonable. Such an approach creates a very subjective area in which the outcome may be more dependent upon the creative ability of accountants and attorneys than upon objective standards.

The department's perspective, on the other hand, was that costs above certain limits were unreasonable, and that those limits were permissable as long as they could at least theoretically exceed all providers' cost. In any event, the debate may prove to be rhetorical. Section 249 of Amended Substitute House Bill 204, as amended by Section 2 of Amended Substitute House Bill 176, provides that the department shall impose "...percentile ceilings in the event the implementation of Amended Substitute House Bill 176 exceeds the estimated funds available." Not only has the general inflationary trend weakened the original budget estimates, but the general loss of state revenue has prompted public speculation that across-the-board budget cuts may be ordered. Reduction of 2% to 5% in spending level de facto results in the funds being insufficient.

Be that as it may, the department has modified the application of the limits on nursing personnel, habilitation personnel, dietary-other, and medical supplies. The upper limits remain. However, the department has specified circumstances in which these limits may be exceeded. The burden of proof has been placed upon the provider to document the reasonableness for the excess. Certain factors are listed as being unacceptable reasons.

Finally, there has been no revisions to the legislatively mandated ceilings—e.g., dietary raw food, prospective rate, and property ownership ceilings.

- The rules regarding the forfeiture of the two profit factors (the efficiency incentive and the return on net equity) for failure to file cost reports timely, cooperate in a medical or fiscal audit, or maintain compliance with federal certification requirements.

  Cost reporting and auditing are essential under either a retrospective system (which is used for costs directly affecting patient care) or a prospective, cost-related system (which is used for costs not directly affecting patient care). State law ORC 5111.26(A)(2) specifically provided for the forfeiture of the efficiency incentive if cost reports are not filed within sixty days.

  The department has reexamined the provisions of the law, and has concluded that revisions are necessary. The department is withdrawing its proposed rules regarding the forfeiture of the return on net equity in all instances, and specified that the forfeiture of the efficiency incentive is permissable only for failure to file cost reports.

- The rules implementing specific provisions of federal regulations.

  State law precludes expenditures which do not earn federal financial participation. ORC 5111.02(D) states: "The program (sic: Medicaid nursing home program) shall conform to the requirements of the 'Social Security Act'..." The attachment to this Prologue c references the federal regulatory cite and the corresponding rule.

The following pages discuss specific objections to particular rules, and the department's reason for either modifying or retaining the rule

5101:3-1-49 Definitions
Many people commented that the definitions were incomplete—for example, omitted the requirement for state licensure. The department agrees and has made the revisions accordingly. Aditional language was suggested in the definition of life care contract and the department agrees.

5101:3-1-52 Prior Authorization
Suggestion was made that the RN on the patient assessment team be empowered to grant prior authorization of medical services. Several problems exists. The first is the time for the review required, and the second is the need to learn a large set of criteria for many different types of services. It should be noted that in most instances, services requiring prior authorization are not services which the long-term care facility itself is responsible for providing (e.g., dental services, ambulance services). The department does not feel that a sufficient rationale was offered to warrant development of special procedures for prior authorization solely because a Medicaid recipient happens to reside in a long-term care facility.

5101:3-1-55 Provider Agreements—All Providers
Objection was raised regarding an existing regulation which permits the department to propose termination of a provider "granted immunity from prosecution of any criminal offense...(which) has a reasonable relationship to the performance of the obligations imposed by virtue of the provider agreement."

Testimony failed to note that this was an existing provision and that the provider had a right to an administrative hearing under Chapter 119 before any termination could be made effective during which the Medicaid payment would continue. The department is not rescinding its existing rule.

Objection was raised regarding suspension or termination as a result of "entry of a judgement in a civil action." This rule simply repeats the provision of ORC 5111.03(C).

5101:3-1-56 Provider Agreement - Nursing Home
Objection was raised regarding retaining a bed for a hospitalized patient for 31 days paragraph (A)(8) when the department only pays for reserving that bed for 24 days. Both provisions are provisions of state law (ORC 5111.02(C)(2) and Section (8)(B)(1) of Amended Substitute House Bill 176). It should be noted, however, that the department did drop the provision of reimbursing the facility at 85% of its per diem during hospitalization (which was a previous requirement adopted pursuant to the Nursing Home Commission's recommendation under department's previous system). This balances out, at least partially, the fact that some days might not be reimbursed.

Objection was raised regarding the rule in paragraph (A)(4) requiring each Title XIX skilled care bed to participate in Title XVIII. It is department's understanding that this is the intent of the General Assembly in enacting ORC 5111.20(B). Medicare/Medicaid eligible residing in a Title XVIII/XIX certified bed have all or a portion of the skilled care paid for by Title XVII

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is pointed out by testifiers that a California court case mandated Medicare to pay for skilled care provided in a Title XIX—only skilled e bed as long as a distinct part of the facility was certified for Medicare. A review of this case [illegible]

where possible, which county welfare department are responsible for...final federal disallowances of federal financial participation and t what extent, and the respective counties shall increase their shares of program expenses as ordered by the Director of the Department o Public Welfare." In such a circumstance, the state would continue to make payments, and collect the amount of any federal disallowance from the county.

5101:3-3-04 Covered Services
Objection was raised that including personal laundry as a covered service was contradicting federal regulations governing covered services. The federal regulations only state what must be covered. States are free to include additional items. Laundry of personal clothing has been a required covered service for many years in Ohio. As a matter of information laundry of personal clothing may soon become a federal mandate. Proposed rules published April 18, 1979, could make this a requirement.

5101:3-3-07 MR Level of Care
The department has revised its final rule to clarify that this level of care is generally intended for those who have a *primary* MR/DD diagnosis and otherwise meet the criteria established in the rule. The rule has also been revised to clarify that although an ICF-MR resident may need occassional services falling under the definition of skilled service, assignment of a SNF level of care is warranted only if overall and ongoing medical needs would result in a SNF level of care determination. This revision was made to recognize concerns raised in testimony that the rule as proposed would have precluded ICFs-MR from providing any services which might be considered to be "skilled."

5101:3-3-10 Emergency Relocation Plan
A comment was made that the department should continue to pay a facility its per diem rate in situations where patients had to be relocated due to an emergency. There are a number of problems with this suggestion. Would the department pay the receiving facility also? If not, would the original facility pay the receiving facility? What if the costs were lower in the receiving facility? The idea is not practical. The department will pay the receiving facility for the care the receiving facility provided.

5101:3-3-11 Relationship of Other Covered Medicaid Services to Long-Term Care Facility Services.
Request was made to modify an existing rule [paragraph (D)(2)] to permit telephone orders for patients in an emergency situation. This particular rule simply sets forth the parameters of the rules affecting physicians, and the physician handbook already contains such a provision. However, the rule has been revised to clarify that the physician visit requirement relates specifically to renewing prescriptions when the refill authorization maximum has been reached.

Request was made that paragraphs (J) and (K) be modified to permit more than one visit per month. The particular paragraphs, as well as the entire rule, summarizes for the long-term care facility's ready reference to the provisions of existing rules known to these providers. These providers know the provisions of those rules.

5101:3-3-12 Patient Assessment
Comment was made regarding the number of visits a nursing home received and the fact that the activities of health survey nurses, PSRO nurses, and patient assessment nurses should be combined to reduce the number of visits. There are different functions being performed—i.e., the health department examines the capacity of a facility, and the PSRO and patient assessment the performance of the facility. Conceptually the department agrees, and did approach the PSROs where they had long-term care responsibility (one-half the state) to assume this task. However, the department was unable to fiscally achieve the goal because PSROs wanted 25% more money to conduct patient assessment than the department had. In part this is due to economies of scale which can be realized when the department assumes activity on a statewide basis.

The other comments were adequately addressed in the department's prologue to the proposed rules.

5101:3-3-13 Computation of Additional Allowance
It was argued that the additional time component (i.e., the time added to the direct delivery time) was not statistically supported. As pointed out in the prologue to the proposed rules, (1) the percentages for nonmeasured services and nonproductive time were derived from a John Hopkins University study of 15 nursing homes in three states over a two year period and (2) the percentage for administrative supervisory overhead was derived from cost reports filed by Ohio nursing homes in the fall of 1979. The basic times for the delivered services was the 35th percentile of the time spent for particular procedures in "quality" nursing homes which spent a greater portion of time with patients. As ceilings such time factors are appropriate, and do exceed the average mean time spent in facilities.

The comment was made that the cost of pool services for nursing personnel should be excluded from the determination of reasonable costs, and should be handled separately. The department recognizes that this is a difficult situation. Temporary use of pools is more than adequately covered by the allocation method. It is the department's perspective that on an ongoing basis, from both a continuity of care perspective and a fiscal perspective, it is better for the nursing homes to pay better salaries, improve fringe benefits and improve working conditions than to rely upon pools for manpower. Since pools are just now emerging, the department feels it prudent not to structure an incentive for their use, although it recognizes in its formula the need for them.

Comments were also made that all supervising nurses, medical directors, pharmacy consultants, etc. should be handled separately and not redirected into the ceiling. The figure the department used was 30% which covered this cost category in all but 12 facilities (the average was about 17%). The allocation is more than adequate, and serves as a safeguard against future rapid cost increases which has been the traditional history of cost reimbursement programs.

5101:3-3-14 Patient Assessment Process
The comment was made that the composition of the patient assessment team (RNs) placed them in a position of judging work of other disciplines (e.g., physical therapists). This statement reflects a misunderstanding of the role of patient assessment. Patient assessment records (1) the services ordered by a physician and planned by the interdisplinary team and (2) rendered by medical and other professionals. It measures "what is," and not "what should be." The identification of questionable care is referred to a physician and supervising nurse and other such medical professionals as necessary for further examination and resolution. This process is described in paragraph (C)(2)(c)(iv).

Several individuals objected to paragraph (B)(3) regarding the lack of appeal regarding patient assessment findings. The department agrees that the language should be modified to clearly state the appeal process. Since the findings are applied at the settlement time in the determination of the ceiling and allowable costs, there is automatically a Chapter 119 hearing. However, since the documentation can be manufactured after-the-fact, notarized copies of disputed findings must be mailed to the department within 24 hours. As a practical matter, the department still does not anticipate disputes. Either the services were ordered and documented or they weren't. Either the services were delivered and documented or they weren't.

ction was raised in paragraph (4)(a) that the department's plans for physician consultation in the event of inadequate plan of care treatment violates the recipient's freedom of choice and right to privacy. The objection seems to be saying that the department should ignore adequate care and treatent. 42 CFR 456.600 provides that there shall be periodic inspection of care and services; 42 CFR 456.602 provides that the inspection team shall consist of a physician as appropriate; 42 CFR 456.608 provides for the personal contact with each recipient and review of medical records; and 42 CFR 456.609 provides that the review shall determine the adequacy of services to meet the health, rehabilitative, and social needs of each recipient. ORC 5111.23(D) provides that "reasonableness of allowable nursing and habilitation personnel and hours shall be based on maximum potential needs pursuant to an assessment of the individual patient needs."

5101:3-3-15 Utilization Control

There were numerous comments regarding the utilization control rules. In one sense, the comments were surprising since these requirements have existed since 1975 and were in most instances only reorganized in the proposed rules. The department has, however, modified the final proposed rules in certain areas. Specifically, the entire section on Utilization Review has been revised to basically repeat federal regulations relative to physician certification and recertification, plan of care, and all sections dealing with facility based SNF U.R. Committees. Generally, then, although the department recognizes concerns raised regarding differing time frames for various utilization control functions and concerns raised regarding the need for extensive medical, psychological, and social evaluation of patients prior to admission, these are federal mandates which the department cannot alter.

5101:3-3-17 Methods and Standards

This rule contains the basic provisions of the rate-setting methodology. The basic provisions are expanded upon in the subsequent rules.

An objection was raised that the definition of covered services in paragraph (H) exceeds the requirements of federal regulations. The federal requirements are minimum requirements which the states are free to add to. Most states do, and in fact the Medicare program includes many services beyond those minimally required for Medicaid. Some of the covered services that are additional to the federal minimums have been covered services for many years in Ohio—e.g., nonlegend drugs, personal laundry, physical therapy, occupational therapy, and social worker services. The other services (e.g., speech therapy, audiology, psychosocial) were added in order to comply with ORC 5111.23(B) and ORC 5111.23(D) which provides that the department shall pay for the allowable costs of nursing and habilitation personnel.

An objection was raised that by permitting the nursing home to pay a physician for review of records, and including that cost as an allowable cost created a situation where the nursing home was practicing medicine and, therefore, was illegal. The precedent cited does not fit the facts of this situation. The patient selects his own physician and receives services as that physician determines appropriate. In order to remove barriers of physician involvement, the department is dropping the paperwork requirement of the physician submitting individual ...es, and is permitting the nursing home to pay for the service (as it does for nursing care, therapy, etc.) for which it will be reimbursed. ...epartment's hospital and clinic program and the Medicare program for nursing homes currently reimburses for physician care. For these reasons and since several people testified in support of the proposal, the department is not withdrawing this rule.

...01:3-3-18 Ceiling for Long-Term Care

...is rule stated that there was no overall ceiling except that the Medicaid rate could not exceed the private pay rate or the average Medicare rate. Objection was raised regarding the prohibition against carry-over [paragraph (A)]. The department's position remains unchanged that the comparison should be on a yearly basis rather than averaging over several years which is what carry-over means.

Objection was raised regarding the fact that the average Medicaid rate could not exceed the average Medicare rate. It was pointed out that HFCA has dropped this requirement, and that it would be unworkable. As pointed out in the prologue to the proposed rules, this requirement is a matter of state law. The comparison would be made on an annual basis as part of the rate setting process.

Objection was raised that the reduction of the Medicaid rate to the average of Medicare affects only the proprietary. This is not accurate as the reduction applies equally in both profit factors—e.g., the efficiency incentive which both proprietary and philanthropic homes earn, and return on net equity which is not earned by philanthropic and some proprietary homes.

Objection was raised regarding the department's approach of reducing the net equity and efficiency incentive in the event the Medicaid rate would exceed the Medicare rate on a state-wide average basis. The suggestion was that such a reduction be on a percent basis. Such an approach, however, is illegal under federal regulation since prorata reductions are not cost-related. Furthermore, such an approach is clearly not in accordance with legislative intent. ORC 5111.24(B) and 5111.25(C) specify the manner in which rates are to be reduced (e.g., the efficiency incentive and the return on net equity). Section 249 of Am. Sub. House Bill 204 was specifically amended by Section 2 of Am. Sub. House Bill 176 to preclude pro-rata reductions.

In response to comments regarding sampling, the department did drop a phrase in paragraph (C) which was superfluous. An objection was also voiced regarding the timing of the reduction. The point was made that the department only knows that Medicare will exceed Medicaid after-the-fact whereas the reduction would take place before the rates are paid.

Other than the obvious fact that it is time-consuming and rarely 100% effective to collect overpayments, it is reasonable that, if the principles used resulted in Medicaid paying more than Medicare in the past, the same effect would occur again if the same principles were used.

5101:3-3-19(A) Ceilings for Nursing and Habilitation Personnel

The department proposed to base a ceiling for nursing and habilitation personnel on a formula consisting of the time required to deliver a particular service multiplied times the wage of the professional required to deliver the service. The time required was the time found necessary in 85% of instances to provide the service and an allocation of time for services not being measured by patient assessment. The wage ... used was 115% of the prevailing wage. The department's perspective was that it is better to base the decision regarding maximum ...nized for nursing and habilitation personnel upon objective criteria rather than subjective determination (e.g., what constitutes skilled ... as opposed to intermediate care as opposed to intermediate care for the mentally retarded.)

...timony was centered around various components of the formula as follows:

(1) Comment: Not enough time was allocated.

Response: The times were derived from a Cleveland Federation of Community Planning study of the time actually spent in six nursing homes generally considered to render quality care and John Hopkin's University study of 16 nursing homes over a two-year period. The times allocated for direct delivery are more than adequate in 85% of all instances while inadequate in 15%. The exceptional situation in

a few instances are compensated by the process of averaging. ORC 5111.23(D) states the number of hours shall be based on "...maximum potential *needs* determined pursuant to an assessment of individual patient *needs*..." (emphasis added). The patient assessment system categorizes needs into twenty groups, with usually four subgroups or a total of 78 distinct service needs. These needs cover all known, measurable, routine needs of patients. In addition, an indirect allocation for nonmeasured serivces was added. Finally the department in its revised rule has provided for a variance for facility's whose particular patient population requires routinely the provision of nonmeasured services in excess of the department's percentage allocation.

(2) Comment: The times do not reflect times necessary in an ICF-MR.

Response: The procedure for the first 14 standards measures the time of the procedure. It is thus reflective of the nature of the procedure which would not substantially vary by condition of the patient. For example, a more difficult patient would receive higher time value under Behavior in addition to the time required for the service. In addition, the unique needs of the mentally retarded are recognized under the habilitation standards. Under these standards, the faciltiy's interdisciplinary team determines the amount and range of services needed by a patient. Standard 15-1 Specialized Services in particular meets these unique characteristics. As a result, there is a built-in safeguard against the under recognition of time since the facility's interdisciplinary team determines not only the range of services but also the amount of time required.

(3) Comment: The times do not reflect time necessary for restorative nursing.

Response: The times were derived from studies conducted in nursing homes generally considered to render quality services. Thus, there was automatically built into them a restorative care element. In addition, a further allocation for restorative care was included in the weighing factors.

(4) Comment: The allocation for the weighing factor was inadequate.

Response: The allocation for nonmeasured services and nonproductive time was derived from a John Hopkin's University study which measured these two items. The allocation for administrative/supervisory time was derived from reports of Ohio nursing homes of the time and dollars actually spent, and represents in excess of 95% of instances. The additional allocation for restorative services was computed on basis of allowing an increased percentage of reimbursable time for service units representing improved functional level. The objection was raised that nursing services purchased from pools should be included in the computation of wages paid direct service personnel rather than administrative/overhead. The department does not see where this would make a significant difference on a statewide basis since the increased personnel costs would be spread across a larger base, and would distort the actual wages paid nursing homes to their staff. It would be preferrable for the nursing home to pay their staff better and retain them than to pay a larger cost to pool service. This expense is more properly an administrative overhead expense for which there is an allocation.

(5) Comment: The allocation of the weighing factor was not applied to all service standards while a provider's cost are applicable to standards.

Response: The weighing factor was deliberately added for those services which do not increase dependence upon institutional services. As a matter of public policy, the department does not want to create a system which would, directly or indirectly, provide fiscal incentives for increasing dependence. As a practical matter, the service standards to which the weighing factor was applied constitute in excess of 90% of all services provided (in many instances up to 98%).

(6) Comment: The standards do not measure all the services rendered by a nursing home.

Response: The standards do represent those variable measurable services *routinely* provided in nursing homes. Those services not measured are of an infrequent nature and are reflected in the allocation for non-measured services. In addition, the department has revised the rule to provide for variances for facilities who routinely provide nonmeasured services in an amount greater than the amount allocated for nonmeasured services.

(7) Comment: The wage component of the formula should not be based on 115% of the statewide average, but upon some other basis such as state employee compensation.

Response: A review of 300 plus cost reports revealed that 115% of the statewide average exceeded in actual salaries paid in 95% of all instances, and exceeds comparable salary schedule paid state employees for RN and LPN by a dollar an hour. It was $.85 a hour less for aides. The department believes that it is preferrable to base the salary component of the ceiling on the prevailing wages being paid rather than civil service classifications which contain unrealistic wages.

Public testimony was offered by Cleveland Hospital Association regarding salaries in Cuyahoga County where the shortage of nurses has resulted in high salaries. The figures quoted as being the average wage in February 1980 ($7.83 for RNs and $5.77 for LPNs in hospitals, and $6.98 for RNs and $5.06 for LPNs in nursing homes) indicate that the wage component used in patient assessment is adequate ($7.80 for RNs and $6.25 for LPNs). The point is that the salary component of the formula will be 115% of the actual salaries *paid* nursing and habilitative personnel *during* the rate year.

(8) Comment: Documentation requirements are excessive and do not reflect the services actually provided and are counter-productive to good nursing care.

Response: As mentioned in the prologue to the proposed rules, the first stage of the review is the measurement of the services needed by a patient as reflected in the physician's orders and plan of care, and the services delivered as reflected in nurse's notes and medical records. This documentation has been certification requirements since 1975. Basic nursing practice requires the recording of services delivered. As minimums, the department requires monthly summaries for most categories of service. It has not generally required (except for medications, gastric tube feeding, etc.) daily recording. In reviews conducted so far, the amount of recording in the majority of facilities has been more than adequate. The linkage of Medicaid reimbursement is the recording of "what is" rather than "what should be."

The second stage of the review (which is not operational) is the determination of the appropriate ranges of services for a particular patient. In this review, the patient assessment staff identify apparent abnormalities and refer these abnormalities for follow-up review by a physician and supervising nurse. Before this data is imputed (and thereby have an effect upon the rate) consultations are held with the patient's physician and the nursing home.

Comment: Insufficient allocation for social services personnel.

Response: The time allocated for service units A and B under standard 1 Behavioral include value for general social service programs (at a ratio of 1 social service worker for sixty residents or 8 minutes per resident per day). In addition, the time spent by social workers in admission/discharge planning is recognized in the weighing factor added for many services. Finally, the specialized services needed for a particular patient are recognized under standard 15-5. However, the department is increasing the time value for social service personnel under standard Behavior from one social worker to sixty residents to one social worker to thirty residents.

In summary, the formula used to determine a nursing home's ceiling of reasonable nursing and habilitation costs contains several component parts. A nursing home does not have to have each of its component parts below the component part of used in the ceiling in order for all of its costs to be recognized. For example (1) the salaries paid its employees may exceed 115% of the statewide average but those employees may be more efficient; (2) a nursing home may employ a different ratio of RNs, LPNs, or aides than suggested by the formula; (3) a nursing home's staff may spend more time for a particular procedure or for particular patients than others; (4) a nursing home may have a greater portion of administrative time than suggested, etc. The basic test is (1) whether the facility's total nursing and habilitation personnel costs are less than the ceiling, and (2) the reasons if the costs exceed the ceiling. As of the date this material was prepared, the ceilings established by patient assessment exceeded the nursing home's 1979 costs by at least $2 per patient day in 94 out of 106 instances. The ceiling was sufficient to cover costs in a variety of nursing homes (e.g., hospital based ECFs, county facilities, public and private ICFs-MR, SNFs/ICFs, and ICFs) of varying sizes in urban and rural counties. The ceiling is, however, a ceiling, and it is probable that some nursing homes will have total costs which exceed these ceilings. Of the twelve that exceeded the ceiling, three had an exceptionally low utilization rate (less than 50%), two had a large percentage of noninstitutional patients (more than 20%), one was a county facility, two were hospital based ECFs with a large percent of ambulatory ICF patients (more than 80%), and two were hospital based ECFs.

However, the department does see some merit in the argument that this is basically an untried new system, that much more data is needed over a longer period of time before the system has proven to be reliable, and that the ceilings are reasonable in practice as well as theory. During at least the first six months following July 1, 1980, the department has provided in its revised rules that (1) the interim allowance may exceed the interim ceiling upon the approval of the department and that (2) the final allowance may exceed the final ceiling provided the provider can document valid reasons (some of the reasons that are acceptable and that are unacceptable are listed) for the excess. In this manner, the department will be able to recognize the unanticipated and the exceptional. However, the burden of proof rests with the provider, and there is no guarantee that costs above the ceilings will be recognized as reasonable.

5101:3-3-19(A)(2) Physician Review

Objection was raised regarding the amount of the dollar ceiling for physician medical review visits. The particular ceiling is the ceiling for ...al visits in nursing homes under the direct physician billing system. The department could not authorize different levels. Finally, objec... was raised based on the frequency of the physician's certification of need. The ceiling however is based upon the frequency of the physician's review of records and updating of the plan of care rather than the certification of need.

01:3-3-19(B) Dietary Costs

...ietary Raw Food—The department had proposed that the ceiling be based upon the USDA liberal cost plan for certain age categories minus the 20% savings as a result of bulk buying. Testimony was offered that, while there is a 20% mark-up between wholesale and retail costs, most nursing homes did not realize that savings as a result of buying from a distributor who delivers to the facility. An exception for Jewish homes was requested because Kosher food was more expensive. Finally, a suggestion was made that the ceiling used should recognize the mixture of patients in a nursing home (age as well as sex).

Amended Substitute House Bill 176 does not specify which USDA food plan be used but only that one be used. The 20% reduction of the liberal cost plan was a recommendation of the Nursing Home Commission. The department does see merit in simplifying the approach and has revised its rule to specify that the USDA liberal food plan for age 55 years of age and older be used without the 20% reduction. Whatever savings are realized by bulk buying are compensated by using a single ceiling regardless of age and sex of the population.

Dietary Cost-Other—Objection was also raised regarding the ceilings proposed for other dietary costs. Without such ceilings, there would be nothing to prevent a nursing home from paying $100,000 for a particular dietary employee (such has previously been claimed), and hiring an excessive number of employees. Under a retrospective system, such costs would be paid unless there was a reasonableness ceiling. ORC 5111.20(A) states: " 'Allowable' costs are costs determined by the department to be reasonable." 42 CFR 447.294 specifies the state Medicaid agency must specify allowable costs and reasonable costs.

However, in the interest of simplicity, the department is withdrawing the subceiling on dietary personnel and the personnel ratio. As a matter of information, an analysis of 200 cost reports indicated that no costs would have been excluded by these subcategories.

The basic thrust of this rule has been revised. The ceiling imposed is an initial ceiling for purposes of rate-setting. Providers whose costs exceed this ceiling can have those costs recognized provided the excess was not caused by excessive salaries or excessive number of employees.

5101:3-3-19(C), (D), and (E) Utilities, Taxes, and Medical Supplies

Objection was raised because of a "ceiling" on property taxes was placed in paragraph (D). The department has proposed no rule establishing a ceiling on property taxes, but is expressing a Title XVIII principle. Since such a disallowance would only be imposed at the settlement, any arbitariness would be subject to a Chapter 119 hearing. It is curious that the same providers who wanted the department to use subjective tests of reasonableness instead of reasonable ceilings in other areas objected to the one area where the department is using a te... of reasonableness.

...on was raised regarding the exclusion of telephone as a utility [paragraph (C)] subject to retrospective adjustment. The Nursing Ho...e Commission's report clarifies that this particular utility was to be included in the prospective cost center.

...ection was raised regarding a ceiling for medical supplies in paragraph (E). ORC 5111.20(A) and 42 CFR 447.294 provide that the ...partment shall determine allowable costs and reasonable costs. However, the department is withdrawing the use of the 95th percentile and substituting the Medicare test of reasonableness—providers will need to prove costs in excess of 115% of statewide average are reasonable.

5101:3-3-20 Allowable G & A Costs
Objections were raised regarding the definitions of allowable and reasonable costs considered in the calculation of the predetermine allowance for general support and administrative costs.

ORC 5111.24(A) states that the allowance shall be based upon "audited actual *allowable* administrative and general services costs..." (emphasis added). ORC 5111.20(A) states " 'allowable costs' are those costs determined by the department to be reasonable..." 42 CFR 447.302(b) states: "Payment rates must not be set lower than rates that the agency reasonably finds to be adequate to reimburse in full the actual allowable costs of a facility that is economically and efficiently operated." The question becomes are the items determined not allowable unreasonable, or are they necessary for the efficient and economical operation of a nursing home? The department's position is that these costs are neither reasonable nor necessary for a home economically and efficiently operated.

5101:3-3-20(A) Occupancy Levels
Statement was made in regard to paragraph (A) that Medicaid can use only certified beds in determining the base over which costs are spread. This ignores the fact that these types of costs must be spread across the entire operation. Since the smaller the base the higher the per unit cost, providers could artificially inflate costs by reducing the number of certified beds and would be in conflict with general accounting principles [42 CFR 447.272 and 42 CFR 447.274(C)]. By using licensed beds, costs are spread across the number of beds the provider is licensed to operate. G & A costs do, in fact, apply to all beds.

The 85% is a minimum test of efficieny. Again, the smaller the base the higher the per unit cost. Facilities could artificially inflate costs by restricting the number of Medicaid certified beds. The 85% test is not a new provision but has been a requirement for several years.

5101:3-3-20(B) Administrator Time
Considerable testimony was advanced regarding the department's proposal to adopt the Nursing Home Commission's findings that a minimum amount of the administrator's time needed to be spent in the nursing home. Many suggested that phraseology be added clarifying that time refers to time usually spent. The department agrees. However, the basic test remains for the reason expressed by one individual who offered testimony as follows:

> I am a professional Nursing Home Administrator, i.e., I do not have any ownership interest in any Nursing Home. I am also a member of the Board of Examiners of Nursing Home Administrators and although I speak for myself and not for the Board, the concerns that I wish to address at least inpart grow out of service on the Board. I support fully the concept of Rule 5101:3-3-20B. I believe a majority of the Board would also. One of the most difficult problems we have to deal with is the "phantom Administrator"—the person whose license hangs on the wall, but who never seems to be there, while an untrained, unlicensed person is actually practicing Nursing Home Administration. The phantom Administrator may be: (1) an owner who hangs his Nursing Home Administrator license on the wall, but having other interests turns over the actual operation of the facility to someone for much less money than he would have to spend to hire a professional licensed Administrator; (2) a properly licensed Administrator who is "lending" his license (often for a fee) to an unlicensed owner; (3) a licensed Administrator who is responsible for so many facilities that each one gets a "lick and a promise" again while day to day operations are run by someone who is untrained and unlicensed. This arrangement can be more "cost effective" than having an Administrator in each home. All of these—and like arrangements—are clearly evasions of the intent of the licensure law, which was to assure quality care by putting the provision of that care under the direction of an individual who had demonstrated as indicated by licensure that he/she had met at least the minimum requirements of knowledge and skill to perform the functions of the position effectively, and who could be held responsible for what went on. The Board has long been aware that these evasions were wide spread, but has been helpless really to do anything about it. Given the ingenuity of some of the people involved, I don't believe this one provision is going to solve the problem, but I personally support it because it is a major step in the right direction. Furthermore, as a Board member I do not feel that this provision is in any way an invasion of the Board's statutory responsibilities, as was suggested in the hearings. It is simply a declaration that the Ohio Department of Public Welfare will no longer fund the evasion of the Administrators licensing statute and the statute's intent. (Having made this beginning I would hope that ODPW would be willing to work on possible further steps with the Board and Ohio Department of Health to control and finally correct this problem.) I would suggest some wording changes to make it clear that the rule does not intend to bar or penalize time away from the facility because of illness, vacations, and attendance at required continuing education. It could read "normally spends" or "usually spends."

5101:3-3-20(C) Administrator Other Duties
The rule in paragraph (C) sets a maximum limit on the amount of compensation a owner pays himself for services rendered. In the past, owners have claimed exorbant salaries (e.g., in excess of $100,000). The cite of the objector to 42 CFR 405.426 confirms that the department must determine the reasonableness of wages claimed and the last sentence of paragraph (C) of this Medicare regulation states reasonableness "may be determined by other appropriate means." Since the department's data does not contain information regarding compensation actually paid for these types of services in other nursing homes, the "other means" proposed by the department is civil service compensation which, by law, is supposed to be the prevailing wage.

5101:3-3-20(D) Administrator Compensation
The rule in paragraph (D) states that the maximum allowable rate an owner may pay himself or another for administrative duties is the prevailing wage owners pay nonrelated individuals. 42 CFR 447.284 establishes the principle of the lower of actual costs or prevailing wage. 42 CFR 405.426 states specifically that it "be such an amount as would ordinarily be paid for comparable services." The department is following a two step process—a determination of the prevailing wage and then allowing up to 50% more based upon the education and experience of the individual. The maximum allowable is added to other G & A costs to which an inflation adjustment is added.

The request was made that the department not drop the geographical variations. The department concurs and will retain geographical va
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:3-3-20(E) Home Office Management Fees
Department had proposed excluding home office costs and management fees in the calculation of the G & A rate, but allowing them in e calculation of an individual provider's costs. This proposal was attacked on a number of grounds: it is a recognized cost under Medicare itle XVIII), it reduces a provider's (and the

The rule in paragraph (C) represented an attempt to be fair with providers over and above the minimum requirements of law—an allowance above the predetermined allowance for patients requiring considerable extra laundry services. Objection was voiced that the department's predetermined allowance for laundry was not computed as required by law (e.g., median plus 4/5 standard deviation). This comment is completely misleading and ignores that the allowance for routine laundry is based upon the median plus 4/5 standard deviation [paragraph (B)], and that this allowance was an additional allowance. Four-fifths of a standard deviation plus .30 brings the allowance close to what providers are saying are the actual costs for incontinent patients.

5101:3-3-22 Cost of Property and Equipment

Comment was made that the department was not recognizing in paragraph (A) the cost of renting or leasing from a related party. It is accurate that the department cannot recognize the actual rent or lease charged one related party to another, but must pay only the underlying costs. Clarification was added by adding a separate rule regarding lease/rent payments from a related party.

There was some confusion regarding the application of the department's regulations in rental/lease situations. The following three examples are illustrative.

- A home was licensed in 1969 at a per bed construction cost of $2.80 per day and is leased at $4.50 per patient day. The ceiling in this example is $3.50 per day [paragraph (C)(3)(b)].
- Subsequent renovations by the original owner increased the per bed cost to $3.75. The ceiling is now $4.50 [paragraph (C)(3)(a)].
- Later, the facility was purchased at a price of $4.25 per bed. The same $4.50 ceiling applies [paragraph (C)(3)(a)].

Objections were raised regarding the restrictive nature of paragraph (D). It is the department's perspective that the allowance for renovation was intended to allow providers who owned older physical facilities to renovate those facilities. Despite the argument to the contrary, it does not seem logical to pay for the renovation of a leased facility when the owner of the facility is receiving lease payments above historical costs. It seems the responsibility of the lessor to maintain the facility.

Objection was raised regarding the department's limit on the net of equity calculation as proposed in paragraphs (F)(1) and (F)(4). The discussion of the inclusion of this item during the deliberations of Amended Substitute House Bill 176 was for individuals who owned and operated their facilities. However, since interest rates have dramatically increased, the department is withdrawing the proposed rules (F)(1) and (F)(4) in order to attract/retain the owner/operator.

5101:3-3-23 Disallowances and Cost Exclusions

This rule sets in one place the various cost disallowances mentioned elsewhere in the rules. Comments on these disallowances and cost exclusions have previously been summarized, as well as the department's response. However, two items are worth repeating.

(1) The department did not propose a penalty for failure to maintain certification compliance or failure to cooperate in a medical or fiscal audit. It did propose that the facility lose the two profit factors. This is not a penalty since it would vary for each facility based on cost. It was the department's perspective that the General Assembly intended the two profit factors for facilities operating within all the parameters of the Medicaid program. However, the department did modify its proposed rule to provide for only the loss of the efficiency incentive when cost reports were not filed.

(2) The department's proposed rule [paragraph (O)] (which is actually a recodified rule currently in existence) actually protects the provider who has no records. Without such a provision, all the provider's expenses would be disallowed.

5101:3-3-23 (C) Disallowance for nondelivery of needed nursing and habilitation services.

The department had proposed that a fiscal disallowance be imposed if a nursing home failed to deliver a service needed by a patient. For example, a patient needed oral care or bathing and did not receive it, a patient needed periodic positioning and did not receive it, a patient needed injections and did not receive them, a patient needed dressings and did not receive them, a patient needed catheter care and did not receive it, a patient needed ostomy care and did not receive it, etc.

The amount of the proposed disallowance was the *lower* of (1) the difference between the dollar value of the service needed and the dollar value of the service delivered or (2) the amount of a facility's cost that would be disallowed if the ceiling for a particular service standard would be reduced to zero. The dollar value figure was the dollar value figure used in the ceiling computation.

Opposition to this concept was voiced on many grounds—e.g., constitutional, legal, procedural, and philosophical. Some of the opposition was based upon an incomplete and inaccurate understanding of the proposed concept and the process.

- Nondelivered services do not reduce the ceiling of nursing and habilitation costs and there is, therefore, no double jeopardy. The ceiling for nursing and habilitation is based, rather, on the service needs of the patient regardless of what services are delivered. The service needed are based upon physician written orders (e.g., prescriptions and plan of care and treatment).
- The proposed disallowance would not be imposed on the rate currently being paid or upon the computation of future rates. First of all, the amount of monies reimbursable for nursing and habilitation services is only the amount actually expended. The facility's reimbursment rate is based upon the facility's cost for rendering needed services. Secondly, the disallowance would be imposed at the time of final settlement.

As a result of the testimony received (including a conference with the individual who was the sponsor of Amended Substitute House Bill 176 and chairman of the reimbursement subcommittee of the Nursing Home Commission), the department is revising this provision in order to precisely implement the legislative intent—i.e., that the department not pay the nursing home for services needed by a patient, but not delivered to that patient. The revision disallows only that portion of a facility's cost associated with the nondelivery of a needed service rather than a fixed amount based upon statewide dollar values or the disallowance of costs if the ceiling for a particular service standard is reduced to zero.

The nature of the testimony of nursing home providers was that the department lacked the authority to disallow costs associated with nondelivered services. The opponents' testimony stated that the provision of state law only allowed for the reduction of the overall nursing ceiling by the amount of nondelivered services (e.g., the difference between the dollar value of services needed and services delivered would be subtracted from the overall ceiling). The department's perspective is that such an interpretation did not achieve the goals improving quality of services. A provider could avoid any consequence for nondelivered services by keeping his costs well below the ceilings. Providers who have been rendering less than adequate care would have no reason not to continue to do so.

rgument was made that basing the proposed disallowance on the difference in dollar values of services needed and services delivered not cost-related because the dollar values represented maximums and not a particular home's cost.

e department recognizes some merit in the argument that the proposed disallowance was not cost-related, and that the disallowance ust be related to the provider's costs. ORC 5111.23(D) states:

> The reasonableness of allowable nursing and habilitation personnel and hours shall be based on maximum potential patient needs determined pursuant to an assessment of individual patient needs when completed as provided in section 5111.29 of the Revised Code, except that no allowance shall be made for nursing or habilitative services identified in a patient assessment as being needed but not provided. Reasonable and allowable nursing and habilitation costs shall be established and adjusted by rule of the Department of Public Welfare.

There is, however, no question that "... no allowance shall be made for nursing or habilitative services identified in a patient assessment as being needed but not provided," and that the department has the authority to establish and adjust by rule reasonable and allowable nursing and habilitation costs. Since the department's reimbursement rate for nursing and habilitation cost is based upon that facility's costs for rendering needed services, the fact that a facility failed to render needed services means that the facility's costs for the difference between the services needed by a patient and the services received by the patient are unreasonable and not related to patient care (i.e., did not result in the delivery of needed care). The department should not be paying for nondelivered care.

A method similar to the statistical technique known as regression analysis can establish that portion of a nursing home's expenditures that would be within a particular category of service. The reduction of a facility's ceiling for those costs to the value of the services actually delivered (i.e., "no allowance shall be made") results in the identification of proportional value of the needed but not delivered service. That value (expressed in terms of a percentage) can be applied to the facility's actual nursing and habilitation costs to determine the amount of the facility's costs associated with the nondelivery of a needed service. Consequently, the department is revising its rule to provide that the nursing and habilitation costs associated with the nondelivery of a needed service are disallowed as being unreasonable.

As noted earlier, the department's patient assessment system automatically establishes the dollar value of services needed and the dollar value of services needed but not delivered. The computation of the dollar values has incorporated within it such variables as the type and frequency of services, the length of time for delivery of services, skill level of professionals generally considered to render the services, and the wages paid those professionals.

The relationship of the dollar value of services needed but not delivered to the dollar value of services needed constitutes a viable percen- e which can then be applied to the facility's cost for nursing and habilitation personnel to determine the amount of that particular facility's ng and habilitation costs which would be disallowed as unreasonable.

formula for determining the disallowance of costs otherwise reimbursable would be applied as shown in the example of a 100 bed cility:

Dollar ceiling	$27.19 per day
Value of services needed but not delivered	$ 0.41 per day
Percentage	1.51%
Facility's cost	$25.72
Facility cost	$ 0.38
Disallowed	(1.51% X 25.72)

In the example above, the facility received payment for delivering needed services. However, it failed to deliver a certain percentage of services needed by patients entrusted to its care. The costs associated with nondelivered services are unreasonable costs. The Medicaid program only meets the reasonable costs of nursing and habilitation services needed and deliverd to patients, and not the costs of needed but not delivered services.

Fiscal disallowance—need for a waiver

Testimony was offered that there needed to be a waiver of the fiscal disallowance provision because the system was too precise in measuring needed services, that there was an element of subjectivity on the part of the patient assessment staff despite the objectivity of the system and that errors would occur whenever human beings are involved. One reason advanced was that the facility's staff might simply fail to record the specific services delivered. Minor recording errors would have no impact except in the areas of injections, catheter care, oxygen therapy, and intravenous feeding. These are particularly necessary to record. The other categories represent ranges of services or broad categories (e.g., spoonfeeding vs. assistance/supervision) where failure to record specific instances have no bearing. The majority of the services require only a monthly recording. However, the department recognizes that this is a new system, and that there may be value in recognizing a 5% margin of error during at least the first six months of implementation. This tolerance factor would compensate for human errors on the part of both the provider and the department. The department is therefore modifying the rule to permit a 5% waiver of liability. The application of the waiver provision in the example cited earlier can be illustrated as follows:

Facility nursing cost	$25.72
5% liability waiver	1.28
Potential disallowance	$ 0.38
Final disallowance	$ 0.00

mony was also offered that the disallowance provision should not apply in situations where the provider was not able to provide the services for reasons outside his control—e.g., therapists or nurses not being available, a nursing strike, etc. While this type of exception seems logical on the surface, it is accurate that "situations outside the provider's control" can be manufactured. For whatever the reasons, the fact he matter is that patients are not receiving the services they need. The nursing home should not accept patients it cannot adequately care for, or should arrange for the transfer of patients to a facility where the patients can receive the services needed.

However, the department does see merit in providing for a waiver of the disallowance provision in the exceptional situations. Since the allowance should be applied during the settlement phase of the annual audit, permissive language has been added to permit a waiver of disallowance based on the provider's documentation up to an additional 5%. The 5% threshold level would permit the recognition of an unanticipated unusual event which might be beyond the control of the provider while maintaining the basic premise that the provider is responsible for delivering the care needed by patients. Since this type of situation cannot be anticipated, the language is permissive and will depend upon the circumstances involved—e.g., the type of service which was not delivered. For example, it is not the intent of the department to provide for a waiver even if the rate of occurrance is less than 5% in situations where patients consistently did not receive services, plans of care were not implemented, etc.

5101:3-3-23(D) & (L) Penalties

Objection was raised regarding the proposed disallowance in paragraph (D) of delinquent taxes and utilities. The exclusion is based upon 42 CFR 447.274(C) which provides that the accrual method of accounting be used. 42 CFR 477.272 defines accrual as the period in which expenses "...are incurred regardless of when they are paid." To allow delinquent taxes to be recognized would be to pay for the taxes twice (once when they are incurred and again when they are paid). However, since this is a Title XVIII principle, the department can modify the rule to speak of only the penalties for delinquent taxes and for utility expenses.

Objection was raised regarding the exclusion of bad debts in paragraph (L) as not being in conformity with federal law. The cite provided (42 CFR 405.420) is applicable only to the Medicare program and not to the Medicaid program. The Medicaid program specifically prohibits the consideration of bad debts (42 CFR 447.282).

5101:3-3-24 Rate Method for New Facilities

Objection was raised that the department's rule was not in conformity with state statute ORC 5111.12(B) for new providers. Since this section is only applicable for nursing, habilitation, dietary, utilities, and property taxes, a literal reading would suggest that only those costs would be granted new providers. The department's proposed rule does use the projected method for these costs of a new provider (the Medicare technique). In addition, the department is recognizing the predetermined G & A cost available to all other providers, and the provider's property costs. There is no similar provision (e.g., using Title XVIII principles) for new providers in the section (ORC 5111.25) dealing with property ownership. In an effort to be fair with providers and taxpayers, the department proposed to recognize both depreciation and interest. However, since rates for property ownership are based upon prior costs which do not exist, the amount allowed for interest in the initial rate year is an average. As pointed out in the prologue to the proposed rules, without the averaging principle, a new provider would have its rate during subsequent years based on the higher rate (which has already beed paid) and, in effect, be paid for one more year of interest than actually incurred.

5101:3-3-25 Rate Adjustment

This particular rule is an example of the department's adopted rules whose origin does not exist in state law in order to have a more equitable formula. There is no provision in state law for rate adjustments except for nursing and habilitation personnel However, the department did propose to adopt rules recognizing rate adjustments in situations where the lack of rate adjustments might raise a significant cash flow problem.

Objection was raised regarding recognizing only electric rate increases in paragraph (A). The reason only electric utility increases were proposed for a rate adjustment is that such increases can cause significant cash flow problems. Other utility increases are usually within the amount computed for inflation. Based on public testimony and the fact that such costs would be subject to retroactive adjustment in any event at the time of settlement, the department is revising this rule to provide for a rate adjustment whenever the costs of all items subject to retrospective settlement [excluding nursing and habilitation which is treated in paragraph (E)] increase more than 5% from the amount allocated in the rate.

Argument was raised in paragraph (B) that it was inappropriate to consider whether the general inflation rate previously granted already covered the cost of a government mandated increase. The department rejects this argument because inflation adjustment is calculated to take into effect anticipated increases. The purpose of this adjustment is to recognize unanticipated government mandated cost increases. However, as a result of a previous rule revision [paragraph (A)], the rule is being revised restricting such increase to the predetermined rate for G & A costs . Other increases are incorporated in paragraph (A) of this rule.

Objection was raised regarding the sample size in paragraph (B) (1). relationship to the number of items being measured. The size of the sample referred to was a sample necessary for 20 + items. In this instance, one to five areas would be sampled. In order to avoid misunderstandings, the department is dropping its mention of the sample size.

Objection was raised regarding the circumstances under which the rate for nursing and habilitation costs would be adjusted in paragraph (E). ORC 5111.23(G) states only that the rate shall be adjusted if it is substantially excessive or substantially inadequate. The department defined substantially as 5% or more. In order to make a judgment as to when the adjustment should be made, the following must be known: (1) what is the ceiling, (2) what is being paid, and (3) what is the provider's current cost.

The department has withdrawn from paragraph (F) its previous rule regarding forfeiture of the two profit factors. It has, however, inserted the provision of state law regarding reducing rate by the amount of the four-fifths deviation for any provider who fails to file cost reports when due. ORC 5111.26(A)(2) states:

> If a home required to submit cost reports does not file the reports within sixty days after the end of the reporting period ... the home shall be paid its current rate minus the retention of four-fifths of one standard deviation above median costs for administrative and general services.

This rate reduction for the time period reports are delinquent applies in all instances when cost reports are required: the year-end cost rep the periodic supplemental reports, and the one-page quarterly report. The authority for all cost reports is the fact that ORC 5111.26(A)(1) reads plural implying more than one report. Authority for the quarterly report is also found at ORC 5111.23(A) which provides that "...nursing and habilitation costs shall be established by rule of the department" and ORC 5111.23(F) which provides for rate adjustments if the interim allowance for nursing and habilitation is excessive or inadequate. The department could not determine whether the allowance was excessive or inadequate unless the nursing costs were reported periodically.